UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
BUREAU FOR GLOBAL HEALTH
OFFICE OF HEALTH, INFECTIOUS DISEASE, AND NUTRITION
USAID/GH/HIDN

GUIDANCE FOR DETAILED IMPLEMENTATION PLANS (DIPS) FOR PVO CHILD SURVIVAL AND HEALTH PROGRAMS

FY 2002

CHILD SURVIVAL AND HEALTH GRANTS PROGRAM
Revised September 2002

GH/HIDN is grateful for the many contributions to this document from public health specialists consulted through the ORC/Macro International Child Survival Technical Support Project (CSTS), other USAID-funded contracts, offices of USAID, and PVOs.

TABLE OF CONTENTS

I. Introduction/Purpose

The guidance set forth in this document serves to assist those PVOs, who were awarded cooperative agreements as a result of the FY 2002 Child Survival and Health Grants Program (CSHGP – previously the Child Survival Grants Program) competitive review process, in drafting Detailed Implementation Plans (DIPs). Due to changes in the DIP review process including a Mini-University event, the due date for the final DIP will be June 30, 2003 with a first draft DIP submitted by April 30, 2003. In addition to this guidance, PVOs should utilize the CSHGP's "Technical Reference Materials" (TRMs) which describe the important elements of the child survival and health interventions and several cross cutting strategies. The DIP should provide: results of baseline studies; changes in program interventions/strategies and/or a revised budget based on those studies; the overall approach to each technical intervention, and a detailed plan of action for the first two years of the project. Thereafter, annual work plans and budgets should be provided (by October 31 of each project year) to the appropriate Cognizant Technical Officer (CTO) for approval. At the time of the DIP, a PVO may change the selection of interventions and implementation strategies from what was proposed in the original Cooperative Agreement, with a clear and sufficient justification for these changes.

The DIP and annual workplan will be used by the CSHGP team and CTO to monitor progress in program implementation. It should also serve as the working document for the PVO field staff guiding day to day implementation and keeping the program on track towards achieving stated targets and results. It is expected that the PVO program will be implemented according to the approved DIP. Any further changes (after the DIP has been approved) in the program description, such as the interventions, site, or beneficiaries must be approved by the PVO's headquarters, appropriate CTO, and the USAID Agreements Officer.

The 2002 DIP guidance was based on input from PVOs in various forums (e.g. CORE Group meeting and the RFA post-conference meeting), CSHGP and CSTS team members. The intention of the new guidance is to ensure that the final product (DIP) is a technically sound document and used as a management and implementation tool. Although the document submitted to the CSHGP team is abbreviated from previous years, the PVOs may use any part or all of the guidance provided in the past in order to structure the development of the DIP in the field and for strengthening capacity of local partners. However, the final DIP submitted to USAID/W should contain only that information requested in this guidance.

The PVO should utilize the CSHGP TRMs as they are key to ensuring that the proposed technical interventions are based on internationally accepted standards and approaches. Both the TRMs as well as the past DIP guidance should be part of the PVO resource materials and institutional memory and utilized by the PVO.

II. DIP Preparation and Review Process

The DIP preparation and review process is intended to enhance the quality of PVO child survival and health programs. Specifically, the process provides the opportunity to:

- collect baseline quantitative and qualitative data to inform program strategies;
- create a shared vision among all program partners, and strengthen partner relationships;

- revise, if necessary, and refine program goals, objectives, and indicators;
- strategize on major interventions;
- plan critical project tasks and activities;
- clarify roles and responsibilities of implementing groups; and
- prioritize planned activities.

Generally, the PVO and its local partners develop the DIP collaboratively at the field level. Many PVOs have found that conducting a "planning workshop" with the appropriate stakeholders greatly facilitates the "buy-in" of those groups into the goals and objectives of the program as well as facilitating implementation. The workshop is an opportunity to review the findings of baseline surveys and develop key sections of the DIP. Translation of the DIP into the local language and distribution copies of the DIP (or key parts of the DIP) to all partners and staff members involved in project implementation are encouraged. This facilitates the full participation of all staff in the program and serves as a "common road map" to guide the program towards achieving its goals and objectives.

Including partners and other stakeholders in the DIP process has in some instances led to the creation of a "technical advisory group," which then during the implementation phase meets on a regular basis to review progress and advise on project implementation. These advisory groups can tap into national and regional technical expertise (universities, MOH at a national level, UNICEF, WHO, other bilateral partners, etc.) to provide input and oversight on the design phase and continuing throughout the project.

DIP Review Process:

For FY 2002 grantees, we are inviting the PVOs to participate in a **face-to-face DIP review as part of an integrated technical workshop or " CSH Mini-University." (NEW this year and discussed with PVOs during the DIP meeting after the FY 2003 RFA Conference).**

PVOs are encouraged to send one HQ staff, the field-based project manager, and a local partner to the extent that this is feasible (budget realignment may be necessary and will be supported). All sessions will be conducted in English, so PVOs should take this into consideration when selecting their team. Please notify Sheila Lutjens or Susan Youll no later than **November 30, 2002** of how many representatives will attend. We will ask for specific names of attendees closer to the date of the Mini-University. If you foresee any problems in having at least one representative at this event, please contact the appropriate CTO so that other arrangements can be made.

This format will benefit the PVO as it allows for interaction between the PVO, CSHGP team and other technical experts to assist in the finalization of the DIP (see revised due dates) while also providing opportunity for technical updates. The Mini-University event is scheduled to coincide with the annual Global Health Council meeting (May 27-May 30) and is tentatively set for June 2-June 6, 2003 in Washington, D.C. In preparation for this Mini-University DIP review, PVOs will need to submit a **DRAFT DIP at least 4 weeks prior to the workshop by April 30, 2003** (this is one month earlier than originally scheduled in the cooperative agreement). This initial draft will be reviewed by the CSHGP team and technical experts and will serve to help inform on topic areas for the Mini-University—CSTS will also send out queries on areas of interest early in the year. Reviewer comments will be provided to participants by the first day of the Mini-University and then discussed, as needed depending on the work done in the intervening month since DIP submission

(the PVO should continue to work on the DIP during the month of May as needed).

The purpose of the workshop is for grantees: to consult with technical experts and colleagues through panel presentation and sessions; to assist with fine-tuning selected CS interventions in terms of programming and technical content; and, to hold consultative discussions with representatives from CSHGP team, CSTS, CORE, CAs, PVO peers, and other technical experts. Final approval of the DIP could occur during the Mini-University workshop or based on comments and suggestions made during the workshop, the PVO team may opt to revise the DIP, consult with partners and then submit a final version to the CSHGP team by June 30, 2003.

The mini-university may include:

- Opportunities for presentation/peer review of DIPS by region (e.g., all the LAC projects will get a chance to hear, at a minimum, about other projects in the region)
- Technical Updates on intervention areas that are addressed in DIPS. At present, we envision that these updates will cover:

  - Basic components of the TRMs
  - Observations from the DIPS reviewed
  - Dialogue/ Q&A between DIP submitters and technical experts.

- Management and M&E related sessions targeted to common issues across DIPS in these areas.
- Opportunities for DIP writers to meet one on one with individuals who have reviewed their documents to discuss specific comments.
- Short follow-on PVO-CSHGP conference meetings (on the same day as the DIP presentation during the Mini University)

As a reminder, the DIP review process does not serve to make funding decisions about the PVO's program since DIPs are required only for already funded programs. Upon returning to the field, it is hoped that the results of the workshop will be shared with the field staff and partners to provide feedback to those involved in the program and its planning process.

Regardless of which option the PVO selects for the DIP review, the CSHGP staff will send a formal letter to the PVO stating DIP approval status.

III. Submission Instructions

1. General formatting instructions:

   - Limit annexes to those that are essential to understand the program (See Section V). All annexes should be in English or accompanied with a translation. One annex should include a copy of the jointly developed and signed agreements, which clearly

delineate the roles and responsibilities of each partner. An organization chart for the project may be helpful to illustrate the various partner roles.

- Use a 12-point font that is clearly legible.

- If a topic in the DIP Guidelines does not apply to the program, please indicate this in the DIP. If the program has not yet obtained sufficient information to fully describe an element, then please describe plans to obtain this information.

- Include in the body of the DIP other relevant aspects of the program that may not be covered in the DIP Guidance. Please include enough detail so that the intervention is clear. This will enable reviewers to provide meaningful feedback.

- On the DIP cover page please include the following: name of PVO, program location (country and district), cooperative agreement number, program beginning and ending dates, date of DIP submission, and (on the cover or on the next page) the names (including consultants) and positions of all those involved in writing and editing the DIP.

2. Complete the online CSHGP Project Data Form for each project. The form can be found at: <http://www.childsurvival.com/projects/dipform/login.cfm>. A password has been assigned to each PVO in order to access and enter project information (and can be used to access all child survival projects for a given PVO). To obtain a PVO password, please contact the CSTS Project directly at (301) 572-0823 or send an email to csts@orcmacro.com. Detailed information on completing the form is available through individual 'Help File' links.

3. The final project DIP is due at GH/HIDN CSHGP on or before **June 30, 2003**. Failure to submit a DIP on time to USAID could result in a material failure, as described in 22 CFR 226.61. If there are circumstances beyond the PVO's control that have had an impact on the ability to complete the DIP on time, please contact the CSHGP project contact person (see attached responsibility list).

4. Send to GH/HIDN CSHGP the original and two (2) copies of each field program DIP, and one diskette of the DIP in Microsoft Word 97. The original hard copy of the DIP should be one-sided and unbound. The two hard copies of the DIP should be double-sided, and bound separately. DIP annexes that are available in hard copy and not on disk may be excluded from the version submitted on diskette.

   Attention: Sheila Lutjens
   USAID/GH/HIDN – Child Survival and Health Grants Program
   Room 3.7.75
   Washington, DC 20523-3700

5. Send CSTS a one-sided unbound copy and an electronic copy (by email, CD-ROM or diskette) to:

   Attention: Deborah Kumper, Administrative Assistant
   ORC MACRO – Child Survival Technical Support Project (CSTS)

11785 Beltsville Drive
Calverton, MD 20705
Deborah.K.Kumper@orcmacro.com

6. Send one copy of the DIP to the concerned USAID Mission.

7. In accordance with USAID AUTOMATED DIRECTIVES SYSTEM (ADS) 540.5.2, please submit one electronic copy of the DIP to the USAID/PPC/CDIE Development Experience Clearinghouse (DEC). Please include the Cooperative Agreement number on the electronic DIP submission. Electronic documents can be sent as email attachments to docsubmit@dec.cdie.org. For complete information on submitting documents to the DEC, see http://www.dec.org/submit/.

IV. DIP Guidance

The following sections should be included in the DIP.

A. Executive Summary

The Executive Summary from each DIP is used by GH/HIDN as an informational document for decision-makers, Congress, public inquiries, the press, and others. Therefore, this section should contain the information that the PVO believes best represents its program. The executive summary is limited to two pages and should briefly include **all** the following (essentially cut and paste from the original application – with changes, if any):

- *Program location.*
- *Problem statement.*
- *Estimated number of beneficiaries, broken down by children under five and women of reproductive age.*
- *Program goals, objectives and major strategies.*
- *A break down of the estimated level of effort devoted to each intervention using the list of interventions in Section I of the FY 2002 RFA* (e.g. immunization – 30%, control of diarrheal disease – 45%, and pneumonia case management – 25%. If IMCI is proposed, do NOT list as IMCI X%, rather break out the component interventions, and list as above, stating that IMCI will be used as a strategy).
- *Local partners involved in program implementation.*
- *The category of the original CSHGP application (entry, new, cost extension, mentoring).*
- *The start and end dates.*
- *The level of funding.*
- *Name and position of the local USAID Mission representative with whom the program has been thoroughly discussed.*
- *Main authors of the document.*
- *Contact person at PVO headquarters for the program.*

B. CSHGP Data Form

Please include a copy of the completed on-line form, <u>including the Rapid CATCH indicators</u>, and place it after the Executive Summary. See "Submission Instructions", #2 (on the previous pages) for details on how to complete the form on-line.

C. Description of DIP Preparation Process

Briefly describe the steps taken to prepare this DIP, as well as project start-up activities which have taken place since the award. Include a list of the staff, partners and various stakeholders who participated in planning, the methods used, the number of days spent on DIP preparation, and planned follow-up activities.

D. Revisions from Original Proposal

Describe the changes made in the DIP from the proposed application, if applicable. If there are changes in the program description (including goals and objectives), budget, site, additions or deletions of child survival interventions, please state these changes and describe the rationale for any changes between these sections in the Cooperative Agreement and those discussed in the DIP. Include in the discussion, any responses to proposal review comments and, if applicable, final evaluation recommendations.

- If there have been changes to the program's site, location, selection of interventions, number of beneficiaries, international training costs, international travel, indirect cost elements, or the procurement plan that have budget implications, include a revised budget with the DIP. The revised budget is to be submitted on revised Forms 424 and 424A with supporting information on all cost changes.

- If there have been no changes, please state this, and do NOT submit a revised budget.

E. Detailed Implementation Plan

Based on the original proposal and a more in-depth analysis/assessment of the health situation in the project site, describe: the overall program monitoring and evaluation plan (see #1 below); a summary of the baseline studies (#2); proposed goal, objectives, and more in-depth description of technical interventions and activities (#3); and a workplan table (#4) which provides a snap shot at any given time, the activities, timeframes, persons responsible, etc. for each intervention/activity.

1. <u>Program Monitoring and Evaluation Plans</u>:

- Describe the current information system in the community and how/if the project's HIS will differ. Describe points of overlapping data and how data will be integrated. Discuss how facility-based data will be combined with community-based data.

- Describe the monitoring tools which will be used (such as PRA, PLA, other participatory methods, LQAS, ISA, QA, others), the tools developed by the project (if any), who will develop the tools, and who will field test the tools and produce them.

- Describe how the data will be collected by including the following descriptions:

  (a) Sources of data (e.g. facility-based records, household surveys, rosters, etc.)
  (b) Process to determine the population denominator and how eligible women, children and newborns will enter and participate in the program.
  (c) System for data collection including: frequency, sources, process, and how the process will be supervised to ensure data quality.
  (d) Indicate how program staff (including that of PVO and partners) and beneficiaries will participate in data collection.

- Describe how and by whom data will be analyzed and used to monitor program progress, improve program processes, and improve program performance. Describe how the results will be shared and used with the stakeholders and partners (e.g. district level health officials, MOH authorities, PVO home office and the larger PVO community). Specify how results may be used for advocacy in country or internationally. Discuss how the community/beneficiaries will use the data and benefit from it.

- For programs that strengthen health worker performance, describe the methods that will be **used to monitor and improve the performance of health workers** and the quality and coverage of intervention activities (including those carried out in cooperation with other organizations).

- Discuss the project's plans for on-going assessments of essential knowledge, skills, practices, and supplies/drugs/equipment of health workers and facilities associated with the project, and use of findings to improve the quality of services.

- Describe **the tools to be used by the project to promote quality of service** (such as: guidelines, training curricula and manuals, protocols, algorithms, performance standards, and supervisory checklists, etc.). Briefly describe how these tools will be used to assess and improve performance.

- Describe how M&E skills of local staff and partners will be assessed and strengthened.

- Discuss operations research ideas that will be carried out during the program.

2. Summary of Baseline and Other Assessments

Provide a summary of the findings of baseline assessments and other quantitative/qualitative analysis carried out that support the proposed interventions/strategies. Include a discussion of any programming priorities identified and/or confirmed as a result of the findings from the baseline assessments and what implications these may have for selected child survival interventions, budget, staffing, etc. Describe any differences between the population proposed in the original application and the population now targeted in this DIP. Include the baseline survey report(s) in an annex to the DIP.

- Briefly describe the types and methodology of baseline assessments conducted by the

project, both qualitative and quantitative. Examples of baseline assessments may include, but are not limited to, a census, a population level baseline survey (i.e., KPC survey), a health care providers assessment (i.e., during a facility assessment or a health worker competency survey), a PVO and or partner capacity assessment. If completed, include baselines of PVO and local partner capacity. Discuss the sampling technique and interview process of the baseline assessments.

- Compare baseline findings with the current country context and constraints, and include the current health status of the population with under-five and maternal mortality rates, nutritional status and major causes of mortality and morbidity. Please cite sources of data.

- Give the most up-to-date coverage estimates in the service area relevant to each intervention. Use intervention specific statistics (e.g. include DPT drop-out rate for EPI).

- Provide the most recent disease surveillance data available for the program area, and discuss the likelihood of complete reporting.

- Discuss MOH policies/strategies and/or case management policies/current services for each intervention.

- Describe overall quality of existing services including client-health worker interaction, standard case management, and availability of drugs.

- PVOs should provide GH/HIDN CSHGP with **all Rapid CATCH** (Core Assessment Tool on Child Health) **Indicators** as part of the baseline assessment and final evaluation (inclusion of these indicators in the mid-term evaluation is optional at this point). It is suggested that in order to collect these indicators, PVOs conduct a population level baseline survey, using the KPC2000+, which includes the Rapid CATCH, and is available on line at: http://www.childsurvival.com/kpc2000/kpc2000.cfm.

- Send the Rapid CATCH data (all records for each indicator) electronically to CSTS (csts@macroint.com) and include a paper copy as an annex to the DIP with the average value for each indicator. Even if some of these core indicators do not relate specifically to project interventions, they provide information on critical, life-saving household behaviors and care-seeking patterns.

- USAID/GH/HIDN believes that collecting, analyzing, interpreting, using, and sharing this information has the potential to save the lives of children and mothers and will use the data for results reporting and to examine trends across the CSHGP portfolio of child survival grants. This information will be essential to ensuring continued support for the program from Congress and tracking changes in child health.

- **PVO programs will not be held accountable for achieving progress on indicators for which they have not proposed specific interventions**.

3. Program Description by Objective, Intervention and Activities

Based on the above assessments and the original applicant's proposal, provide program objectives and explain how these objectives assist with achieving the CSHGP's Intermediate Results. Under each objective, describe the CSH interventions and activities that will be implemented to achieve the objective. In addition to the guidance provided below, please refer to the Technical Reference Materials (TRMs) as a reference guide for specifics per intervention.

INTERVENTION SPECIFIC APPROACH

Under each intervention area address the following (as applicable).

Behavior Change Communication

- Based on the recent KPC and other assessments discuss how current beliefs, knowledge and practices and care-seeking behaviors of mothers and families and other caretakers will influence each technical intervention and how the program will work to influence change in those behaviors which negatively impact on the health of women and children.

- Describe how information from the research will be used to contribute to the change of practices and behaviors.

- Activities that will be carried out to facilitate the behavior change at each level from policy to community and individual.

- Describe the training and supervision that will be undertaken.

Please see the TRM section on Behavior Change for an example of the above.

Quality Assurance

- Provide examples of how Quality Assurance (QA) methods will be applied for each intervention.

- Describe the training and supervision that will be undertaken

Availability of Drugs, Vaccines, Micronutrients, Equipment, etc…

- What commodities are essential to the success of the intervention?

- Discuss how reliable the supply of essential commodities is now and how the supply will be ensured during the life of the program, including the source from which the program will obtain supplies (such as antibiotics, vaccines, or micronutrients, etc.).

- Discuss likely constraints to the success of "supply" activities and approaches to overcome these constraints.

- Discuss how the supply will be sustained after the end of the program.

- Describe how the quality of supplies will be monitored (e.g. cold chain maintenance).

- Discuss how the program will ensure safety (i.e. disposal of syringes and sharps, misuse of antibiotics, safe use of insecticides for re-dipping nets).

- Describe the training and supervision that will be undertaken

4. Work Plan (Table):

The "table" should facilitate easy monitoring of specific program activities. The PVO may use its organization's table format, however it should include the following detailed information (a sample workplan template is provided in Attachment A.):

- The results-based objectives for selected child survival interventions;
- Indicators used to measure program objectives and method(s) of measurement;
- Major activities planned by level (i.e., household, community, health facility, district, etc.) with identified target groups;
- Specific time frames for the implementation of major activities;
- Responsible personnel identified from PVO and partners; and,
- Benchmarks and targets for activities including any tools and/or existing resources to be used to monitor progress towards objectives and targets.

V. Annexes

1. Response to Application Debriefing: Discuss the weaknesses identified in the debriefing package summary scoresheet and external reviewer comments, and how they will be addressed in the program. Attach a copy of the summary score sheet and the external reviewer comments in this Annex.

2. Response to Final Evaluation Recommendations (if applicable): If this is a DIP for a cost extension, and a final evaluation has been completed, describe how the program is addressing each of the recommendations made in the final evaluation. Reference the section of the DIP that addresses each recommendation.

3. Report of baseline assessments: Include a description of the methods employed, and copies of questionnaires and other tools used during the baseline assessment.

4. Agreements: Memorandums of Understanding, agreements, or Terms of References signed with other organizations.

5. Resumes/CVs and job descriptions of key personnel at HQ and in the field (if different from application).

6. Other Annexes (as necessary)

Maps, RAPID CATCH summary data (use reporting template), Organizational Chart.

ATTACHMENT A

SAMPLE WORKPLAN TEMPLATE

Program GOAL:_____

Child Survival Intervention (and % Level of Effort):_____

Objective #1:			
Indicators (with Measurement Method): Indicator #1 – (i.e., *percentage* o*f children aged **x** to **y** months who….*) (Measurement Method) Indicator #2 (Measurement Method)			
Major Activities	**Time Frames**	**Personnel**	**Benchmarks/ Targets**
Household			
Activity	Dates	Staff	Benchmarks/Targets
Activity	Dates	Staff	Benchmarks/Targets
Activity	Dates	Staff	Benchmarks/Targets
Community			
Activity	Dates	Staff	Benchmarks/Targets
Activity	Dates	Staff	Benchmarks/Targets
Health Facility			
Activity	Dates	Staff	Benchmarks/Targets
Activity	Dates	Staff	Benchmarks/Targets
District			
Activity	Dates	Staff	Benchmarks/Targets

- ***NOTE***: Try to keep objectives comparable to internationally accepted ones. See the KPC 2000 Modules and Technical Reference Materials for sources of recognized indicators.

Other resources:

PVC RFA 1999 Results Framework Overview PPT
http://www.childsurvival.com/documents/ppt/results/index.htm

KPC Field Guide, August 2001, p. 3-5 for an example of Objectives and Indicators within a Results Framework for a Child Survival Intervention
http://www.childsurvival.com/documents/ppt/results/index.htm

ATTACHMENT B: FY 2003 Child Survival and Health Grants Program

Country	Primary	CTO†
Angola	Susan Youll	Susan Youll
Azerbaijan	Tom Hall	Sheila Lutjens
Bangladesh	Tom Hall	Sheila Lutjens
Bolivia	Susan Youll	Susan Youll
Burkina Faso	Tom Hall	Susan Youll
Cambodia	Sheila Lutjens	Sheila Lutjens
Cameroon	Tom Hall	Sheila Lutjens/Susan Youll
DRC	Sharon Mills	Sheila Lutjens
Egypt	Susan Youll	Susan Youll
Ethiopia	Susan Youll	Susan Youll
Ghana	Tom Hall	Sheila Lutjens
Guatemala	Sharon Mills	Sheila Lutjens
Guinea	Tom Hall	Susan Youll
Haiti	Susan Youll	Susan Youll
Honduras	Sheila Lutjens	Sheila Lutjens
India	Tom Hall	Sheila Lutjens/Susan Youll
Indonesia	Sheila Lutjens	Sheila Lutjens
Kenya	Sharon Mills	Sheila Lutjens/Susan Youll
Kyrgyzstan	Tom Hall	Sheila Lutjens
Madagascar	Tom Hall	Sheila Lutjens/Susan Youll
Malawi	Susan Youll	Susan Youll
Mali	Tom Hall	Susan Youll
Mozambique	Sharon Mills	Susan Youll
Nepal	Tom Hall	Susan Youll
Nicaragua	Sharon Mills	Sheila Lutjens/Susan Youll
Peru	Sharon Mills	Sheila Lutjens/Susan Youll
Philippines	Tom Hall	Sheila Lutjens
Rwanda	Sharon Mills	Sheila Lutjens
Senegal	Tom Hall	Sheila Lutjens/Susan Youll
South Africa	Sharon Mills	Susan Youll
Tajikistan	Tom Hall	Sheila Lutjens/Susan Youll
Uganda	Sharon Mills	Susan Youll
Uzbekistan	Tom Hall	Sheila Lutjens
Vietnam	Sheila Lutjens	Sheila Lutjens
Yemen	Tom Hall	Susan Youll
Zambia	Sharon Mills	Sheila Lutjens/Susan Youll

† May Change

Sheila Lutjens – Program Manager, slutjens@usaid.gov, 202-712-5734
Susan Youll – Sr. Project Officer, syoull@usaid.gov, 202-712-1444
Tom Hall – Technical Advisor, thall@usaid.gov, 202-712-1692
Sharon Mills – Technical Advisor, (sarscott-mills@usaid.gov, 202-712-4014
Nicole Barcikowski – Program Assistant, nbarcikowski@usaid.gov, 202-712-4655